

110TH CONGRESS
1ST SESSION

H. R. 2351

To expand the number of individuals and families with health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 16, 2007

Ms. KAPTUR (for herself, Mr. LATOURETTE, and Mr. CLAY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To expand the number of individuals and families with health insurance coverage, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Coverage, Affordability, Responsibility, and Eq-
6 uity Act of 2007” or the “HealthCARE Act of 2007”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—STATE WAIVERS

Sec. 101. State waivers.

TITLE II—IMPROVING QUALITY AND SAFETY THROUGH PREVENTIVE SERVICES, CARE COORDINATION, AND THE USE OF HEALTH INFORMATION TECHNOLOGY

Sec. 201. Additional waiver authority.

TITLE III—INCREASING HEALTH CARE COVERAGE

Subtitle A—Medicaid and SCHIP

Sec. 301. State option to offer medicaid coverage based on need.

Sec. 302. State option to provide coverage of children under SCHIP in excess of the State's allotment.

Subtitle B—Refundable Tax Credit for Health Insurance Costs of Low-Income Individuals and Families

Sec. 311. Credit for health insurance costs of certain low-income individuals.

Sec. 312. Advance payment of credit for health insurance costs of eligible low-income individuals.

TITLE IV—IMPROVING ACCESS TO HEALTH PLANS

Sec. 401. Definitions.

Sec. 402. Establishment of health insurance purchasing pools.

Sec. 403. Purchasing pools.

Sec. 404. Purchasing pool operators.

Sec. 405. Contracts with participating insurers.

Sec. 406. Options for health benefits coverage.

Sec. 407. Enrollment process for eligible individuals.

Sec. 408. Plan premiums.

Sec. 409. Enrollee premium share.

Sec. 410. Payments to purchasing pool operators and payments to participating insurers.

Sec. 411. State-based reinsurance programs.

Sec. 412. Coverage under individual health insurance.

Sec. 413. Use of premium subsidies to unify family coverage with members enrolled in medicaid and SCHIP.

Sec. 414. Coverage through employer-sponsored health insurance.

Sec. 415. Participation by small employers.

Sec. 416. Report.

Sec. 417. Authorization of appropriations.

TITLE V—NATIONAL ADVISORY COMMISSION ON EXPANDED ACCESS TO HEALTH CARE

Sec. 501. National Advisory Commission on Expanded Access to Health Care.

Sec. 502. Congressional action.

TITLE I—STATE WAIVERS

SEC. 101. STATE WAIVERS.

(a) IN GENERAL.—Notwithstanding any other provision of law, a State may apply to the Secretary of Health and Human Services (in this Act referred to as the “Secretary”) for waivers of such provisions of law as may be necessary for the State to implement policies that make comprehensive, affordable health coverage available for all State residents, including access to essential benefits with limits on cost-sharing, as provided in the most recent report under section 501(e)(2).

(b) REQUIREMENTS.—In order to ensure that waivers under this section benefit rather than harm health care consumers, a State shall not be eligible for a waiver under this section unless—

(1) the State reasonably expects to achieve a level of enrollment in coverage described in subsection (a) that is at least equal to the level of coverage (taking into account the number of insured individuals, covered benefits, and premium and out-of-pocket costs to the consumer for such coverage) that the State would have achieved if the State had fully implemented the coverage options available under titles III and IV of this Act;

1 (2) no individual who would have qualified for
2 assistance under the State medicaid program under
3 title XIX of the Social Security Act or the State
4 children's health insurance program under title XXI
5 of such Act, as of either the date of the waiver re-
6 quest or the date of enactment of this Act, will be
7 denied eligibility for such program, have a reduction
8 in benefits under such program, have reduced access
9 to geographically and linguistically appropriate care
10 or essential community providers, or be subject to
11 increased premiums or cost-sharing under the waiver
12 program under this section; and

13 (3) the State agrees to comply with such stand-
14 ards or guidelines as the Secretary of Health and
15 Human Services may require to ensure that the re-
16 quirements of paragraphs (1) and (2) are satisfied.

17 (c) FEDERAL PAYMENTS.—

18 (1) IN GENERAL.—The Secretary of Health and
19 Human Services shall pay a State with a waiver ap-
20 proved under this section an amount each quarter
21 equal to the sum of—

22 (A) the Federal payments the State and
23 residents of the State (including, but not lim-
24 ited to, through the credit allowed under section
25 36 of the Internal Revenue Code of 1986 for

health insurance costs) would have received if the State had exercised the coverage options under titles III and IV of this Act with respect to residents of the State who have not attained age 65; and

(B) the amount of any grants authorized by this Act that the State would have received if the State had applied for such grants.

(2) ADDITIONAL PAYMENT FOR MEDICARE BENEFICIARIES UNDER AGE 65.—

(A) IN GENERAL.—In the case of a State that elects to enroll an individual described in subparagraph (B) in coverage described in subsection (a), the amount described in paragraph (1) with respect to a quarter shall be increased by the amount described in subparagraph (C).

(B) INDIVIDUAL DESCRIBED.—An individual is described in this subparagraph if the individual—

(i) has not attained age 65;

(ii) is eligible for coverage under title XVIII of the Social Security Act; and

(iii) voluntarily elects to enroll in coverage described in subsection (a).

1 (C) AMOUNT DESCRIBED.—The amount
 2 described in this subparagraph is the amount
 3 equal to the amount that the Federal Govern-
 4 ment would have incurred with respect to a
 5 quarter for providing coverage to an individual
 6 described in subparagraph (B) under title
 7 XVIII of the Social Security Act (42 U.S.C.
 8 1395 et seq.).

9 (d) IMPLEMENTATION DATE.—No State may submit
 10 a request for a waiver under this section before October
 11 1, 2011.

12 **TITLE II—IMPROVING QUALITY**
 13 **AND SAFETY THROUGH PRE-**
 14 **VENTIVE SERVICES, CARE CO-**
 15 **ORDINATION, AND THE USE**
 16 **OF HEALTH INFORMATION**
 17 **TECHNOLOGY**

18 **SEC. 201. ADDITIONAL WAIVER AUTHORITY.**

19 (a) IN GENERAL.—Notwithstanding the require-
 20 ments to submit a state waiver under title I, the Secretary
 21 shall establish a process by which States may apply for
 22 a waiver to implement policies that emphasize the use of
 23 preventive services, care coordination by a personal physi-
 24 cian, and health information technology (in this section
 25 referred to as a qualified patient-centered medical home).

1 (b) DEFINITIONS.—For purposes of this title:

2 (1) QUALIFIED PATIENT-CENTERED MEDICAL
3 HOME.—The term “qualified patient-centered med-
4 ical home” or “PC–MH” means a physician-directed
5 practice that has voluntarily participated in a quali-
6 fication process to demonstrate it has the capabili-
7 ties to achieve improvements in the management and
8 coordination of care of eligible beneficiaries, includ-
9 ing those with multiple chronic diseases, by incor-
10 porating attributes of the care management model.

11 (2) CARE MANAGEMENT MODEL.—The term
12 “care management model” means a model that uses
13 health information and other physician practice in-
14 novations to improve the management and coordina-
15 tion of care provided to patients with one or more
16 chronic illnesses. Attributes of the model include the
17 following:

18 (A) Practices advocate for their patients to
19 support the attainment of optimal, patient-cen-
20 tered outcomes that are defined by a care plan-
21 ning process driven by a compassionate, robust
22 partnership between physicians, patients, and
23 the patient’s family.

24 (B) Evidence-based medicine and clinical
25 decision-support tools guide decision making.

1 (C) Physicians in the practice accept ac-
2 countability for continuous quality improvement
3 through voluntary engagement in performance
4 measurement and improvement.

5 (D) Patients actively participate in deci-
6 sion-making and feedback is sought to ensure
7 patients' expectations are being met.

8 (E) Information technology is utilized ap-
9 propriately to support optimal patient care, per-
10 formance measurement, patient education, and
11 enhanced communication.

12 (F) Practices go through a voluntary rec-
13 ognition process by an appropriate non-govern-
14 mental entity to demonstrate that they have the
15 capabilities to provide patient centered services
16 consistent with the medical home model.

17 (G) Patients and families participate in
18 quality improvement activities at the practice
19 level.

20 (3) PATIENT CENTERED MEDICAL HOME REIM-
21 BURSEMENT METHODOLOGY.—The patient centered
22 medical home reimbursement methodology is a
23 methodology to reimburse physicians in qualified
24 PC–MH practices based on the value of the services

1 provided by such practices. Such methodology shall
2 include, at a minimum the following:

3 (A) Recognition of the value of physician
4 and clinical staff work associated with patient
5 care that falls outside the face-to-face visit,
6 such as the time and effort spent on educating
7 family caregivers and arranging appropriate fol-
8 low-up services with other health care profes-
9 sionals, such as nurse educators.

10 (B) Services associated with coordination
11 of care both within a given practice and be-
12 tween consultants, ancillary providers, and com-
13 munity resources.

14 (C) Recognition of expenses that the PC-
15 MH practices will incur to acquire and utilize
16 health information technology, such as clinical
17 decision support tools, patient registries and/or
18 electronic medical records.

19 (D) Reimbursement for separately identifi-
20 able email and telephonic consultations, either
21 as separately-billable services or as part of a
22 global management fee.

23 (E) Recognition of the value of physician
24 work associated with remote monitoring of clin-
25 ical data using technology.

1 (F) Allowance for separate fee-for-service
2 payments for face-to-face visits.

3 (G) Recognition of case mix differences in
4 the patient population being treated within the
5 practice.

6 (H) Recognition and sharing of savings
7 from reduced hospitalizations associated with
8 physician-guided care management in the office
9 setting.

10 (I) Allowance for additional payments for
11 achieving measurable and continuous quality
12 improvements.

13 (4) PERSONAL PHYSICIAN.—The term “per-
14 sonal physician” means a physician who practices in
15 a qualified PC–MH and whom the practice has de-
16 termined has the training to provide first contact,
17 continuous and comprehensive care for the whole
18 person, not limited to a specific disease condition or
19 organ system.

20 (5) ELIGIBLE BENEFICIARY.—The term “eligi-
21 ble beneficiary” means a beneficiary enrolled under
22 the Medicaid or SCHIP program or other State resi-
23 dent who selects a primary care or principal care
24 physician in a qualified PC–MH as their personal
25 physician.

1 (6) PATIENT-CENTERED MEDICAL HOME QUALI-
 2 FICATION.—The PC–MH qualification is a process
 3 whereby an interested practice will voluntarily sub-
 4 mit information to an objective external private-sec-
 5 tor entity that is recognized and deemed by the state
 6 or by the Secretary to make the determination as to
 7 whether the practice has the attributes of a qualified
 8 PC–MH based on standards the Secretary shall es-
 9 tablish.

10 (c) REPORT AND EVALUATION.—States shall submit
 11 an annual report to the Secretary that describes initiatives
 12 it has taken to encourage the provision of care through
 13 a patient-centered medical home as described in this sec-
 14 tion.

15 **TITLE III—INCREASING HEALTH** 16 **CARE COVERAGE**

17 **Subtitle A—Medicaid and SCHIP**

18 **SEC. 301. STATE OPTION TO OFFER MEDICAID COVERAGE**

19 **BASED ON NEED.**

20 (a) STATE OPTION.—Section 1902(a)(10)(A)(ii) of
 21 the Social Security Act (42 U.S.C. 1396a) is amended—

22 (1) by striking “or” at the end of subclause
 23 (XVIII);

24 (2) by adding “or” at the end of subclause
 25 (XIX); and

1 (3) by adding at the end the following:

2 “(XX) who are not otherwise eli-
 3 gible for medical assistance under this
 4 title and whose income does not ex-
 5 ceed such income level as the State
 6 may establish, expressed as a percent-
 7 age (not to exceed 100) of the income
 8 official poverty line (as defined by the
 9 Office of Management and Budget,
 10 and revised annually in accordance
 11 with section 673(2) of the Omnibus
 12 Budget Reconciliation Act of 1981)
 13 applicable to a family of the size in-
 14 volved;”.

15 (b) INCREASED FMAP.—Section 1905 of the Social
 16 Security Act (42 U.S.C. 1396d) is amended—

17 (1) in the first sentence of subsection (b)—

18 (A) by striking “and (4)” and inserting
 19 “(4)”; and

20 (B) by inserting before the period the fol-
 21 lowing: “, and (5) in the case of a State that
 22 meets the conditions described in paragraph (1)
 23 of subsection (y), the Federal medical assist-
 24 ance percentage shall be equal to the need-

1 based enhanced FMAP described in paragraph
2 (2) of subsection (y)”; and
3 (2) by adding at the end the following:

4 “(y)(1) For purposes of clause (5) of the first sen-
5 tence of subsection (b), the conditions described in this
6 subsection are the following:

7 “(A) The State provides medical assistance to
8 individuals described in subsection
9 (a)(10)(A)(ii)(XX).

10 “(B) The State uses streamlined enrollment
11 and outreach measures to all individuals described in
12 subparagraph (A) including—

13 “(i) the same application and retention
14 procedures (such as 1-page enrollment forms
15 and enrollment by mail) used by the majority of
16 State programs under title XXI during the pre-
17 ceding year; and

18 “(ii) outreach efforts proportional in scope
19 and reasonably expected effectiveness to those
20 employed by the State during a comparable
21 stage of implementation of the State’s program
22 under title XXI.

23 “(C) The State applies eligibility standards and
24 methodologies under this title with respect to indi-
25 viduals residing in the State who have not attained

1 age 65 that are not more restrictive (as determined
2 under section 1902(a)(10)(C)(i)(III)) than the
3 standards and methodologies that applied under this
4 title with respect to such individuals as of July 1,
5 2007.

6 “(2)(A) For purposes of clause (5) of the first sen-
7 tence of subsection (b), the need-based enhanced FMAP
8 for a State for a fiscal year, is equal to the Federal med-
9 ical assistance percentage (as defined in the first sentence
10 of subsection (b)) for the State increased, subject to sub-
11 paragraph (B), by such percentage increase as would com-
12 pensate all States for the additional expenditures that
13 would be incurred by all States if the States were to pro-
14 vide medical assistance to all individuals whose income
15 does not exceed 100 percent of the income official poverty
16 line (as defined by the Office of Management and Budget,
17 and revised annually in accordance with section 673(2) of
18 the Omnibus Budget Reconciliation Act of 1981) applica-
19 ble to a family of the size involved and who are eligible
20 for such assistance only on the basis of section
21 1902(a)(10)(A)(ii)(XX).

22 “(B) In the case of a State that provides medical as-
23 sistance to individuals described in section
24 1902(a)(10)(A)(ii)(XX) but limits such assistance to indi-
25 viduals with income at or below a percentage of the income

1 official poverty line (as defined by the Office of Manage-
 2 ment and Budget, and revised annually in accordance with
 3 section 673(2) of the Omnibus Budget Reconciliation Act
 4 of 1981) applicable to a family of the size involved that
 5 is less than 100, the Secretary shall reduce the need-based
 6 enhanced FMAP otherwise determined for the State under
 7 subparagraph (A) by a proportion based on the national
 8 income distribution of all individuals in all States who are
 9 (regardless of whether such individuals are enrolled under
 10 this title) eligible for medical assistance only on the basis
 11 of section 1902(a)(10)(A)(ii)(XX).”.

12 (c) CONFORMING AMENDMENTS.—Section 1905(a) of
 13 the Social Security Act (42 U.S.C. 1396d(a)) is amended
 14 in the matter preceding paragraph (1)—

15 (1) by striking “or” at the end of clause (xii);

16 (2) by adding “or” at the end of clause (xiii);

17 and

18 (3) by inserting after clause (xiii) the following:

19 “(xiv) individuals who are eligible for medical
 20 assistance on the basis of section
 21 1902(a)(10)(A)(ii)(XX);”.

22 (d) EFFECTIVE DATE.—The amendments made by
 23 this section take effect on October 1, 2008, and apply to
 24 medical assistance provided on or after that date, without

1 regard to whether final regulations to carry out such
2 amendments have been promulgated by such date.

3 **SEC. 302. STATE OPTION TO PROVIDE COVERAGE OF CHIL-**
4 **DREN UNDER SCHIP IN EXCESS OF THE**
5 **STATE'S ALLOTMENT.**

6 (a) IN GENERAL.—Title XXI of the Social Security
7 Act (42 U.S.C. 1397aa et seq.) is amended by adding at
8 the end the following:

9 **“SEC. 2111. STATE OPTION TO PROVIDE COVERAGE OF**
10 **CHILDREN IN EXCESS OF THE STATE'S AL-**
11 **LOTMENT.**

12 “(a) STATE OPTION.—In the case of a State that
13 meets the condition described in subsection (b), the fol-
14 lowing shall apply:

15 “(1) Notwithstanding section 2105 and without
16 regard to the State's allotment under section 2104,
17 the Secretary shall pay the State an amount for
18 each quarter equal to the enhanced FMAP of ex-
19 penditures incurred in the quarter that are described
20 in section 2105(a)(1).

21 “(2) The Secretary shall reduce the State's al-
22 lotment under section 2104, for the first fiscal year
23 for which the State amendment described in sub-
24 section (b) applies, and for each fiscal year there-
25 after, by an amount equal to the amount that the

1 Secretary determines the State would have expended
2 to provide child health assistance to targeted low-in-
3 come children during that fiscal year if that State
4 had not elected the State option to provide such as-
5 sistance in accordance with this section.

6 “(3) Subsections (f) and (g) of section 2104
7 shall not apply to the State’s reduced allotment
8 (after the application of paragraph (2)).

9 “(b) CONDITION DESCRIBED.—For purposes of sub-
10 section (a), the condition described in this subsection is
11 that the State has made an irrevocable election, through
12 a plan amendment, to provide child health assistance to
13 all targeted low-income children residing in the State
14 (without regard to date of application for assistance) and
15 to cover health services listed in the State plan whenever
16 medically necessary.”.

17 (b) EFFECTIVE DATE.—The amendment made by
18 this section takes effect on October 1, 2008, and applies
19 to child health assistance provided on or after that date,
20 without regard to whether final regulations to carry out
21 such amendment have been promulgated by such date.

1 **Subtitle B—Refundable Tax Credit**
 2 **for Health Insurance Costs of**
 3 **Low-Income Individuals and**
 4 **Families**

5 **SEC. 311. CREDIT FOR HEALTH INSURANCE COSTS OF CER-**
 6 **TAIN LOW-INCOME INDIVIDUALS.**

7 (a) IN GENERAL.—Subpart C of part IV of sub-
 8 chapter A of chapter 1 of the Internal Revenue Code of
 9 1986 (relating to refundable credits) is amended by redesh-
 10 ignating section 36 as section 37 and inserting after sec-
 11 tion 35 the following new section:

12 **“SEC. 36. HEALTH INSURANCE COSTS OF ELIGIBLE LOW-IN-**
 13 **COME INDIVIDUALS.**

14 “(a) IN GENERAL.—In the case of an individual,
 15 there shall be allowed as a credit against the tax imposed
 16 by this subtitle for the taxable year an amount equal to
 17 the applicable percentage of the amount paid by the tax-
 18 payer (or on behalf of the taxpayer) for coverage of the
 19 taxpayer or qualifying family members under qualified
 20 health insurance for eligible coverage months beginning in
 21 such taxable year.

22 “(b) APPLICABLE PERCENTAGE.—For purposes of
 23 this section—

24 “(1) IN GENERAL.—Subject to paragraph (2),
 25 the term ‘applicable percentage’ means the standard

1 Government contribution (determined for full-time
2 Federal employees enrolling in coverage for which
3 such contribution is not limited by section
4 8906(b)(1) of title 5, United States Code) for an
5 employee enrolled in a health benefits plan under
6 chapter 89 of title 5, United States Code, for the
7 calendar year in which the taxable year begins, ex-
8 pressed as a percentage of the total premium for
9 such plan.

10 “(2) INCREASED PERCENTAGE FOR CERTAIN
11 TAXPAYERS.—

12 “(A) IN GENERAL.—In the case of a tax-
13 payer whose adjusted gross income for the pre-
14 ceding taxable year does not exceed 150 percent
15 of the poverty level, the applicable percentage
16 determined under paragraph (1) shall be in-
17 creased by such percentage points as the Sec-
18 retary determines will fully compensate such an
19 individual for the individual’s limited pur-
20 chasing power in comparison to individuals
21 whose adjusted gross income equals the average
22 adjusted gross income for all Federal employ-
23 ees, to the extent that the amount of the result-
24 ing increase in the credit amount for all such
25 eligible low-income individuals for the taxable

1 year is not reasonably expected to exceed the 5
2 percentage point dollar amount for that year, as
3 determined under subparagraph (B).

4 “(B) DETERMINATION OF 5 PERCENTAGE
5 POINT DOLLAR AMOUNT.—For purposes of sub-
6 paragraph (A), the 5 percentage point dollar
7 amount for any taxable year is the product of—

8 “(i) the total number of individuals
9 receiving credits under this section for
10 such year; and

11 “(ii) the amount equal to 5 percent of
12 the average health insurance premium
13 amount to which such credits are applied.

14 “(C) RULE OF CONSTRUCTION.—Nothing
15 in this paragraph shall be construed to prevent
16 the Secretary from establishing more than 1
17 level of supplemental assistance that provides
18 greater assistance to individuals with lower in-
19 come, determined as a percentage of poverty.

20 “(3) APPLICATION OF FEHBP COVERAGE CAT-
21 EGORIES TO DETERMINATION OF CREDIT.—The per-
22 centages described in paragraphs (1) and (2) shall
23 be applied to a taxpayer consistent with the coverage
24 categories (such as self or family coverage) applied

1 with respect to a health benefits plan under chapter
2 89 of title 5, United States Code.

3 “(c) MAXIMUM PREMIUM AMOUNT.—The amount
4 paid for qualified health insurance taken into account
5 under subsection (a) for any taxable year shall not exceed
6 an amount equal to the capped premium established for
7 the applicable State under section 404(c)(10) of the
8 Health Coverage, Affordability, Responsibility, and Equity
9 Act of 2007 for the calendar year in which the such tax-
10 able year begins.

11 “(d) ELIGIBLE COVERAGE MONTH.—For purposes of
12 this section—

13 “(1) IN GENERAL.—The term ‘eligible coverage
14 month’ means any month if during such month the
15 taxpayer or a qualifying family member—

16 “(A) is an eligible low-income individual;

17 “(B) is covered by qualified health insur-
18 ance, the premium for which is paid by the tax-
19 payer (or on behalf of the taxpayer);

20 “(C) does not have other specified cov-
21 erage; and

22 “(D) is not imprisoned under Federal,
23 State, or local authority.

24 “(2) JOINT RETURNS.—In the case of a joint
25 return, the requirement of paragraph (1)(A) shall be

1 treated as met with respect to any month if at least
2 1 spouse satisfies such requirement.

3 “(e) ELIGIBLE LOW-INCOME INDIVIDUAL.—For pur-
4 poses of this section—

5 “(1) IN GENERAL.—The term ‘eligible low-in-
6 come individual’ means an individual—

7 “(A) who has not attained age 65;

8 “(B) whose adjusted gross income does not
9 exceed 200 percent of the poverty level;

10 “(C) who is ineligible for the medicaid pro-
11 gram or the State children’s health insurance
12 program under title XIX or XXI of the Social
13 Security Act (other than under section 1928 of
14 such Act);

15 “(D) who has limited access to health in-
16 surance coverage through the employer of the
17 individual or a member of the individual’s fam-
18 ily (either because the employer does not offer
19 such coverage to the individual or because the
20 employee contribution for such coverage would
21 exceed an amount equal to 5 percent of the
22 household income of such individual, as deter-
23 mined in accordance with paragraph (2));

24 “(E) who applies for a credit under this
25 section not later than 60 days after receiving

1 notice of potential eligibility for such credit,
2 under procedures established by the Secretary;
3 and

4 “(F) who resides in a State where the eli-
5 gibility standards and methodologies applied
6 under the medicaid and State children’s health
7 insurance programs with respect to individuals
8 residing in the State who have not attained age
9 65 are not more restrictive (as determined
10 under section 1902(a)(10)(C)(i)(III) of the So-
11 cial Security Act) than the standards and meth-
12 odologies that applied under such programs
13 with respect to such individuals as of July 1,
14 2007.

15 “(2) DETERMINATION OF ELIGIBILITY.—

16 “(A) SCHIP AGENCY.—

17 “(i) IN GENERAL.—The determination
18 of whether an individual is an eligible low-
19 income individual for purposes of this sec-
20 tion shall be made by the State agency
21 with responsibility for determining the eli-
22 gibility of individuals for assistance under
23 the State children’s health insurance pro-
24 gram under title XXI of the Social Secu-
25 rity Act.

1 “(ii) APPLICATION OF SCREEN AND
2 ENROLL REQUIREMENTS.—

3 “(I) IN GENERAL.—The State
4 agency referred to in clause (i) shall
5 ensure that individuals applying for a
6 certificate of eligibility are screened
7 for potential eligibility under the med-
8 icaid and State children’s health in-
9 surance programs and that individuals
10 found through screening to be eligible
11 for assistance under such a program
12 are enrolled for assistance under the
13 appropriate program. To the max-
14 imum extent possible pursuant to
15 State options under title XIX of the
16 Social Security Act, and notwith-
17 standing any otherwise applicable pro-
18 vision of, or State plan provision
19 under, such title, screening and enroll-
20 ment activities described in the pre-
21 vious sentence shall use the proce-
22 dures employed by the State chil-
23 dren’s health insurance program oper-
24 ated under title XXI of the Social Se-
25 curity Act, if such procedures differ

1 from those ordinarily employed by the
2 State program operated under title
3 XIX of such Act.

4 “(II) NO DELAY OF ISSUANCE OF
5 CERTIFICATE.—The application of the
6 screen and enroll requirements of
7 clause (i) shall not delay the issuance
8 of a certificate of eligibility to an indi-
9 vidual for purposes of this section.
10 The State agency referred to in clause
11 (i) shall adopt procedures to ensure
12 that an individual issued a certificate
13 of eligibility under this paragraph who
14 is subsequently determined to be eligi-
15 ble for the State medicaid program
16 under title XIX of the Social Security
17 Act or the State children’s health in-
18 surance program under XXI of such
19 Act shall be enrolled in the appro-
20 priate program without an interrup-
21 tion in the individual’s health insur-
22 ance coverage.

23 “(B) STANDARDS.—

1 “(i) IN GENERAL.—An individual is
2 an eligible low-income individual for pur-
3 poses of this section if—

4 “(I) on the basis of the individ-
5 ual’s tax return for the preceding tax-
6 able year, the individual meets the re-
7 quirements of paragraph (1)(B), and
8 the individual otherwise satisfies the
9 requirements of paragraph (1), or

10 “(II) the individual is determined
11 to satisfy the requirements of para-
12 graph (1) after the application of the
13 same eligibility methodologies as
14 would apply for purposes of deter-
15 mining the eligibility of an individual
16 for assistance under the State chil-
17 dren’s health insurance program
18 under title XXI of the Social Security
19 Act.

20 “(ii) APPLICATION OF SCHIP INCOME
21 DETERMINATION METHODOLOGIES.—For
22 purposes of clause (i)(II), determinations
23 of income levels shall be made using the
24 methodologies described in that clause, to
25 the extent such methodologies for

1 ascertaining household income differ from
2 any otherwise applicable method for deter-
3 mining adjusted gross income or the defini-
4 tion of adjusted gross income.

5 “(C) CERTIFICATE OF ELIGIBILITY.—

6 “(i) IN GENERAL.—An individual who
7 is determined to be an eligible low-income
8 individual shall be issued a certificate of
9 eligibility by the State agency referred to
10 in subparagraph (A).

11 “(ii) CERTIFICATE AMOUNT.—Such
12 certificate shall indicate the applicable per-
13 centage of the amount paid for coverage
14 under qualified health insurance that the
15 individual is eligible for under this section
16 (including any supplemental assistance
17 which the individual may be eligible for
18 under subsection (b)(2), unless the indi-
19 vidual elects to not receive such supple-
20 mental assistance).

21 “(iii) 12-MONTH PERIOD OF ISSUE.—
22 The certificate of eligibility shall apply for
23 a 12-month period from the date of issue,
24 notwithstanding any changes in household
25 circumstances following the individual’s ap-

1 plication for a credit under this section or
2 supplemental assistance.

3 “(D) SUPPLEMENTAL ASSISTANCE.—The
4 State agency described in subparagraph (A)
5 shall determine an individual’s eligibility for
6 supplemental assistance under subsection (b)(2)
7 based on the methodologies referred to in sub-
8 paragraph (B)(ii).

9 “(f) QUALIFYING FAMILY MEMBER.—For purposes
10 of this section—

11 “(1) IN GENERAL.—The term ‘qualifying family
12 member’ means the taxpayer’s spouse and any de-
13 pendent of the taxpayer. Such term does not include
14 any individual who is not an eligible low-income indi-
15 vidual under subsection (e)(1).

16 “(2) SPECIAL DEPENDENCY TEST IN CASE OF
17 DIVORCED PARENTS, ETC.—If paragraph (2) of sec-
18 tion 152(e) applies to any child with respect to any
19 calendar year, in the case of any taxable year begin-
20 ning in such calendar year, such child shall be treat-
21 ed as described in paragraph (1)(B) with respect to
22 the custodial parent (within the meaning of section
23 152(e)(3)) and not with respect to the noncustodial
24 parent.

1 “(g) QUALIFIED HEALTH INSURANCE.—For pur-
2 poses of this section—

3 “(1) IN GENERAL.—The term ‘qualified health
4 insurance’ means any of the following:

5 “(A) Coverage under an insurance plan
6 participating in a purchasing pool established
7 pursuant to section 403 of the Health Cov-
8 erage, Affordability, Responsibility, and Equity
9 Act of 2007.

10 “(B) Coverage under individual health in-
11 surance pursuant to section 412 of such Act.

12 “(C) Coverage, pursuant to section 413 of
13 such Act, under the medicaid program or the
14 State children’s health insurance program if 1
15 or more family members qualifies for coverage
16 under such program.

17 “(D) Coverage, pursuant to section 414 of
18 such Act, under an employer-sponsored insur-
19 ance plan, including—

20 “(i) coverage under a COBRA con-
21 tinuation provision (as defined in section
22 9832(d)(1));

23 “(ii) State-based continuation cov-
24 erage provided under a State law that re-
25 quires such coverage;

1 “(iii) coverage voluntarily offered by a
 2 former employer of the individual or family
 3 member; or

4 “(iv) coverage under a group health
 5 plan that is available through the employ-
 6 ment of the individual or a family member.

7 “(2) EXCEPTION.—The term ‘qualified health
 8 insurance’ shall not include—

9 “(A) a flexible spending or similar ar-
 10 rangement; and

11 “(B) any insurance if substantially all of
 12 its coverage is of excepted benefits described in
 13 section 9832(c).

14 “(3) DEFINITIONS.—For purposes of this sub-
 15 section—

16 “(A) EMPLOYER-SPONSORED INSUR-
 17 ANCE.—

18 “(i) IN GENERAL.—The term ‘em-
 19 ployer-sponsored insurance’ means any in-
 20 surance which covers medical care under
 21 any health plan maintained by any em-
 22 ployer (or former employer) of the tax-
 23 payer or the taxpayer’s spouse.

24 “(ii) TREATMENT OF CAFETERIA
 25 PLANS.—For purposes of clause (i), the

1 cost of coverage shall be treated as paid or
2 incurred by an employer to the extent the
3 coverage is in lieu of a right to receive cash
4 or other qualified benefits under a cafe-
5 teria plan (as defined in section 125(d)).

6 “(B) INDIVIDUAL HEALTH INSURANCE.—

7 The term ‘individual health insurance’ means
8 any insurance which constitutes medical care
9 offered to individuals other than in connection
10 with a group health plan and does not include
11 Federal- or State-based health insurance cov-
12 erage.

13 “(h) OTHER SPECIFIED COVERAGE.—For purposes
14 of this section, an individual has other specified coverage
15 for any month if, as of the first day of such month—

16 “(1) COVERAGE UNDER MEDICARE.—Such indi-
17 vidual is entitled to benefits under part A of title
18 XVIII of the Social Security Act or is enrolled under
19 part B of such title.

20 “(2) CERTAIN OTHER COVERAGE.—Such indi-
21 vidual—

22 “(A) is enrolled in a health benefits plan
23 under chapter 89 of title 5, United States Code;
24 or

1 “(B) is entitled to receive benefits under
2 chapter 55 of title 10, United States Code.

3 “(i) FEDERAL POVERTY LEVEL; POVERTY LEVEL;
4 POVERTY.—For purposes of this section, the terms ‘Fed-
5 eral poverty level’, ‘poverty level’, and ‘poverty’ mean the
6 income official poverty line (as defined by the Office of
7 Management and Budget, and revised annually in accord-
8 ance with section 673(2) of the Omnibus Budget Rec-
9 onciliation Act of 1981) applicable to a family of the size
10 involved.

11 “(j) SPECIAL RULES.—

12 “(1) COORDINATION WITH ADVANCE PAYMENTS
13 OF CREDIT.—With respect to any taxable year, the
14 amount which would (but for this subsection) be al-
15 lowed as a credit to the taxpayer under subsection
16 (a) shall be reduced (but not below zero) by the ag-
17 gregate amount paid on behalf of such taxpayer
18 under section 7527A for months beginning in such
19 taxable year.

20 “(2) COORDINATION WITH OTHER DEDUCTIONS
21 AND CREDITS.—Amounts taken into account under
22 subsection (a) shall not be taken into account in de-
23 termining any deduction allowed under section
24 162(l) or 213. The amount of any credit otherwise

1 allowed under this section shall be reduced by the
2 amount of any credit allowed under section 35.

3 “(3) HEALTH SAVINGS ACCOUNT DISTRIBUTIONS.—Amounts distributed from a health savings
4 account (as defined in section 223(d)) or an Archer
5 MSA (as defined in section 220(d)) shall not be
6 taken into account under subsection (a).

7 “(4) DENIAL OF CREDIT TO DEPENDENTS.—No
8 credit shall be allowed under this section to any indi-
9 vidual with respect to whom a deduction under sec-
10 tion 151 is allowable to another taxpayer for a tax-
11 able year beginning in the calendar year in which
12 such individual’s taxable year begins.

13 “(5) BOTH SPOUSES ELIGIBLE LOW-INCOME IN-
14 DIVIDUALS.—The spouse of the taxpayer shall not
15 be treated as a qualifying family member for pur-
16 poses of subsection (a), if—
17 poses of subsection (a), if—

18 “(A) the taxpayer is married at the close
19 of the taxable year;

20 “(B) the taxpayer and the taxpayer’s
21 spouse are both eligible low-income individuals
22 during the taxable year; and

23 “(C) the taxpayer files a separate return
24 for the taxable year.

1 “(6) MARITAL STATUS; CERTAIN MARRIED IN-
2 DIVIDUALS LIVING APART.—Rules similar to the
3 rules of paragraphs (3) and (4) of section 21(e)
4 shall apply for purposes of this section.

5 “(7) INSURANCE WHICH COVERS OTHER INDI-
6 VIDUALS.—For purposes of this section, rules simi-
7 lar to the rules of section 213(d)(6) shall apply with
8 respect to any contract for qualified health insurance
9 under which amounts are payable for coverage of an
10 individual other than the taxpayer and qualifying
11 family members.

12 “(8) TREATMENT OF PAYMENTS.—For pur-
13 poses of this section:

14 “(A) PAYMENTS BY SECRETARY.—Any
15 payment made by the Secretary on behalf of
16 any individual under section 7527A (relating to
17 advance payment of credit for health insurance
18 costs of eligible low-income individuals) shall be
19 treated as having been made by the taxpayer
20 (or on behalf of the taxpayer) on the first day
21 of the month for which such payment was
22 made.

23 “(B) PAYMENTS BY TAXPAYER.—Any pay-
24 ment made by the taxpayer (or on behalf of the
25 taxpayer) for eligible coverage months shall be

1 treated as having been so made on the first day
2 of the month for which such payment was
3 made.

4 “(9) REGULATIONS.—

5 “(A) IN GENERAL.—The Secretary, in con-
6 sultation with the Secretary of Health and
7 Human Services, shall administer the credit al-
8 lowed under this section and shall prescribe
9 such regulations and other guidance as may be
10 necessary or appropriate to carry out this sec-
11 tion, section 6050W, and section 7527A.

12 “(B) ELIGIBILITY DETERMINATIONS.—
13 Such regulations shall include such standards
14 as the Secretary of Health and Human Services
15 may specify with respect to the requirements
16 for eligibility determinations under subsection
17 (e)(2).

18 “(C) MEASURES TO COMBAT FRAUD AND
19 ABUSE.—Such regulations shall include appro-
20 priate procedures to deter, detect, and penalize
21 fraudulent efforts to obtain a credit under this
22 section by individuals, providers of qualified
23 health insurance, and others.”.

24 (b) CONFORMING AMENDMENTS.—

1 (1) Paragraph (2) of section 1324(b) of title
 2 31, United States Code, is amended by inserting “or
 3 section 36” after “section 35”.

4 (2) The table of sections for subpart C of part
 5 IV of chapter 1 of the Internal Revenue Code of
 6 1986 is amended by redesignating the item relating
 7 to section 36 as an item relating to section 37 and
 8 by inserting before such item the following new item:

“Sec. 36. Health insurance costs of eligible low-income individuals.”.

9 (c) EFFECTIVE DATE.—The amendments made by
 10 this section shall apply to taxable years beginning after
 11 December 31, 2009.

12 (d) REIMBURSEMENT FOR ADMINISTRATIVE COSTS
 13 INCURRED IN DETERMINING ELIGIBILITY FOR CREDIT.—

14 (1) IN GENERAL.—The Secretary of Health and
 15 Human Services shall reimburse States for the rea-
 16 sonable administrative costs incurred in making eli-
 17 gibility determinations in accordance with section
 18 36(e) of the Internal Revenue Code of 1986 (as
 19 added by subsection (a)). Such reimbursement shall
 20 not apply to State costs required under the medicaid
 21 or State children’s health insurance programs.

22 (2) APPLICATION.—A State desiring reimburse-
 23 ment under this subsection shall submit an applica-
 24 tion to the Secretary of Health and Human Services

1 in such manner, at such time, and containing such
 2 information as the Secretary may require.

3 (3) APPROPRIATION.—Out of any money in the
 4 Treasury of the United States not otherwise appro-
 5 priated, there are appropriated such sums as may be
 6 necessary to carry out this subsection.

7 **SEC. 312. ADVANCE PAYMENT OF CREDIT FOR HEALTH IN-**
 8 **SURANCE COSTS OF ELIGIBLE LOW-INCOME**
 9 **INDIVIDUALS.**

10 (a) IN GENERAL.—Chapter 77 of the Internal Rev-
 11 enue Code of 1986 (relating to miscellaneous provisions)
 12 is amended by inserting after section 7527 the following
 13 new section:

14 **“SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR HEALTH**
 15 **INSURANCE COSTS OF ELIGIBLE LOW-IN-**
 16 **COME INDIVIDUALS.**

17 “(a) GENERAL RULE.—Not later than August 1,
 18 2009, the Secretary shall establish a program for making
 19 payments on behalf of certified individuals to providers of
 20 qualified health insurance (as defined in section 36(g)) for
 21 such individuals.

22 “(b) LIMITATION ON ADVANCE PAYMENTS DURING
 23 ANY TAXABLE YEAR.—The Secretary may make pay-
 24 ments under subsection (a) only to the extent that the
 25 total amount of such payments made on behalf of any indi-

vidual during the taxable year is not reasonably expected to exceed the applicable percentage (as defined in section 36(b)) of the amount paid by the taxpayer (or on behalf of the taxpayer) for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

“(c) CERTIFIED INDIVIDUAL.—For purposes of this section, the term ‘certified individual’ means any individual for whom a health coverage eligibility certificate is in effect.

“(d) HEALTH COVERAGE ELIGIBILITY CERTIFICATE.—For purposes of this section, the term ‘health coverage eligibility certificate’ means any written statement that an individual is an eligible low-income individual (as defined in section 36(e)) if such statement provides such information as the Secretary may require for purposes of this section and is issued by the State agency responsible for administering the State children’s health insurance program under title XXI of the Social Security Act.”.

(b) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating

1 to disclosure of returns and return information for
2 purposes other than tax administration) is amended
3 by adding at the end the following new paragraph:

4 “(21) DISCLOSURE OF RETURN INFORMATION
5 FOR PURPOSES OF CARRYING OUT A PROGRAM FOR
6 ADVANCE PAYMENT OF CREDIT FOR HEALTH INSUR-
7 ANCE COSTS OF ELIGIBLE LOW-INCOME INDIVID-
8 UALS.—The Secretary may disclose to providers of
9 health insurance for any certified individual (as de-
10 fined in section 7527A(c)) return information with
11 respect to such certified individual only to the extent
12 necessary to carry out the program established by
13 section 7527A (relating to advance payment of cred-
14 it for health insurance costs of eligible low-income
15 individuals).”.

16 (2) PROCEDURES AND RECORDKEEPING RE-
17 LATED TO DISCLOSURES.—Paragraph (4) of section
18 6103(p) of such Code is amended by striking “or
19 (20)” each place it appears and inserting “(20), or
20 (21)”.

21 (3) UNAUTHORIZED INSPECTION OR DISCLO-
22 SURE OF RETURNS OR RETURN INFORMATION.—Sec-
23 tion 7213(a)(2) of such Code is amended by striking
24 “or (20)” and inserting “(20), or (21)”.

25 (c) INFORMATION REPORTING.—

1 (1) IN GENERAL.—Subpart B of part III of
 2 subchapter A of chapter 61 of the Internal Revenue
 3 Code of 1986 (relating to information concerning
 4 transactions with other persons) is amended by in-
 5 serting after section 6050V the following new sec-
 6 tion:

7 **“SEC. 6050W. RETURNS RELATING TO CREDIT FOR HEALTH**
 8 **INSURANCE COSTS OF ELIGIBLE LOW-IN-**
 9 **COME INDIVIDUALS.**

10 “(a) REQUIREMENT OF REPORTING.—Every person
 11 who is entitled to receive payments for any month of any
 12 calendar year under section 7527A (relating to advance
 13 payment of credit for health insurance costs of eligible
 14 low-income individuals) with respect to any certified indi-
 15 vidual (as defined in section 7527A(c)) shall, at such time
 16 as the Secretary may prescribe, make the return described
 17 in subsection (b) with respect to each such individual.

18 “(b) FORM AND MANNER OF RETURNS.—A return
 19 is described in this subsection if such return—

20 “(1) is in such form as the Secretary may pre-
 21 scribe; and

22 “(2) contains—

23 “(A) the name, address, and TIN of each
 24 individual referred to in subsection (a);

1 “(B) the number of months for which
2 amounts were entitled to be received with re-
3 spect to such individual under section 7527A
4 (relating to advance payment of credit for
5 health insurance costs of eligible low-income in-
6 dividuals);

7 “(C) the amount entitled to be received for
8 each such month; and

9 “(D) such other information as the Sec-
10 retary may prescribe.

11 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
12 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
13 QUIRED.—Every person required to make a return under
14 subsection (a) shall furnish to each individual whose name
15 is required to be set forth in such return a written state-
16 ment showing—

17 “(1) the name and address of the person re-
18 quired to make such return and the phone number
19 of the information contact for such person; and

20 “(2) the information required to be shown on
21 the return with respect to such individual.

22 The written statement required under the preceding sen-
23 tence shall be furnished on or before January 31 of the
24 year following the calendar year for which the return
25 under subsection (a) is required to be made.”.

1 (2) ASSESSABLE PENALTIES.—

2 (A) Subparagraph (B) of section
3 6724(d)(1) of such Code (relating to defini-
4 tions) is amended by striking “or” at the end
5 of clause (xix), by striking “, and” at the end
6 of clause (xx) and inserting “, or”, and by add-
7 ing at the end the following new clause:

8 “(xxi) section 6050W (relating to re-
9 turns relating to credit for health insur-
10 ance costs of eligible low-income individ-
11 uals), and”.

12 (B) Paragraph (2) of section 6724(d) of
13 such Code is amended by striking the period at
14 the end of subparagraph (CC) and inserting “,
15 or”, and by adding after such subparagraph the
16 following new subparagraph:

17 “(DD) section 6050W (relating to returns
18 relating to credit for health insurance costs of
19 eligible low-income individuals).”.

20 (d) CLERICAL AMENDMENTS.—

21 (1) ADVANCE PAYMENT.—The table of sections
22 for chapter 77 of the Internal Revenue Code of 1986
23 is amended by inserting after the item relating to
24 section 7527 the following new item:

“Sec. 7527A. Advance payment of credit for health insurance costs of eligible
low-income individuals.”.

1 (2) INFORMATION REPORTING.—The table of
 2 sections for subpart B of part III of subchapter A
 3 of chapter 61 of such Code is amended by inserting
 4 after the item relating to section 6050V the fol-
 5 lowing new item:

“Sec. 6050W. Returns relating to credit for health insurance costs of eligible
 low-income individuals.”.

6 (e) EFFECTIVE DATE.—The amendments made by
 7 this section shall take effect on January 1, 2010.

8 **TITLE IV—IMPROVING ACCESS** 9 **TO HEALTH PLANS**

10 **SEC. 401. DEFINITIONS.**

11 In this title:

12 (1) ELIGIBLE INDIVIDUAL.—The term “eligible
 13 individual” means an individual with respect to
 14 whom a tax credit is allowed under section 36 of the
 15 Internal Revenue Code of 1986 (as added by section
 16 311).

17 (2) EMPLOYER.—The term “employer” includes
 18 a not-for-profit employer.

19 (3) PARTICIPATING INSURER.—The term “par-
 20 ticipating insurer” means an entity with a contract
 21 under section 405(a).

22 (4) PRIVATE GROUP HEALTH INSURANCE
 23 PLAN.—The term “private group health insurance
 24 plan” means a plan offered by a participating in-

1 surer that provides health benefits coverage to eligi-
 2 ble individuals and that meets the requirements of
 3 this title.

4 (5) PURCHASING POOL OPERATOR.—The term
 5 “purchasing pool operator” means the entity des-
 6 ignated by the State under section 404.

7 (6) SECRETARY.—The term “Secretary” means
 8 the Secretary of Health and Human Services.

9 (7) SMALL EMPLOYER.—The term “small em-
 10 ployer” means an employer with not less than 2 and
 11 not more than 100 employees.

12 **SEC. 402. ESTABLISHMENT OF HEALTH INSURANCE PUR-**
 13 **CHASING POOLS.**

14 There is established a program under which the Sec-
 15 retary shall ensure that each eligible individual has the
 16 opportunity to enroll, through a purchasing pool operator,
 17 in a private group health insurance plan offered by a par-
 18 ticipating insurer under this title.

19 **SEC. 403. PURCHASING POOLS.**

20 (a) ESTABLISHMENT OF PURCHASING POOLS.—Each
 21 State participating in the program under this title shall
 22 establish a purchasing pool that is available to each eligi-
 23 ble individual who resides in the State.

24 (b) TYPES OF PURCHASING POOLS.—

1 (1) IN GENERAL.—A purchasing pool estab-
2 lished under subsection (a) shall be 1 of the fol-
3 lowing:

4 (A) A statewide purchasing pool operated
5 by the State.

6 (B) A statewide purchasing pool operated
7 on behalf of the State by the Director of the
8 Office of Personnel Management, or the des-
9 ignee of such Director.

10 (2) OPM OPERATED POOL.—In the case of a
11 statewide purchasing pool described in paragraph
12 (1)(B), the Director of the Office of Personnel Man-
13 agement or the Director’s designee, may limit par-
14 ticipating insurers in such pool to those described in
15 section 405(e), except that the Director or such des-
16 ignee shall ensure that additional private group
17 health insurance plans participate in such a pool to
18 the extent necessary to meet the requirements of
19 section 404(c)(9).

20 (c) STATE ELECTION PROCESS.—

21 (1) IN GENERAL.—Each State participating in
22 the program under this title shall notify the Sec-
23 retary, not later than January 4, 2009, of the type
24 of purchasing pool that applies to residents of the
25 State.

1 (2) DEFAULT CHOICE.—If a State participating
 2 in the program under this title fails to notify the
 3 Secretary of the type of purchasing pool elected by
 4 the State by the date described in paragraph (1),
 5 the State shall be deemed to have elected the type
 6 of purchasing pool described in subsection (b)(1)(B).

7 (3) CHANGE OF ELECTION.—The Secretary
 8 shall establish procedures under which a State par-
 9 ticipating in the program under this title may
 10 change the election of the type of purchasing pool
 11 applicable to residents of the State.

12 **SEC. 404. PURCHASING POOL OPERATORS.**

13 (a) DESIGNATION.—Each State shall designate a
 14 purchasing pool operator that shall be responsible for op-
 15 erating the purchasing pool established under section
 16 403(a). A purchasing pool operator may be (or, to have
 17 1 or more of its functions performed, may contract with)
 18 a private entity that has entered into a contract with the
 19 State if such entity meets requirements established by the
 20 Secretary for purposes of the program under this title.

21 (b) OPERATION SIMILAR TO FEHBP.—Each pur-
 22 chasing pool operator shall operate the purchasing pool
 23 established under section 403(a) in a manner that is simi-
 24 lar to the manner in which the Director of the Office of
 25 Personnel Management operates the Federal employees’

1 health benefits program under chapter 89 of title 5,
2 United States Code, including (but not limited to) the per-
3 formance of the specific functions described in subsection
4 (c).

5 (c) SPECIFIC FUNCTIONS DESCRIBED.—The specific
6 functions described in this subsection include the fol-
7 lowing:

8 (1) Each purchasing pool operator shall offer
9 one-stop shopping for eligible individuals to enroll
10 for health benefits coverage under private, group
11 health insurance plans offered by participating in-
12 surers.

13 (2) Each purchasing pool operator shall limit
14 participating insurers to those that meet the condi-
15 tions for participation described in this title.

16 (3) Each purchasing pool operator shall nego-
17 tiate (or, in the case of a purchasing pool described
18 in section 403(b)(1)(B), shall negotiate or otherwise
19 determine) bids and terms of coverage with insurers.

20 (4) Each purchasing pool operator shall provide
21 eligible individuals with comparative information on
22 private group health insurance plans offered by par-
23 ticipating insurers.

24 (5) Each purchasing pool operator shall assist
25 eligible individuals in enrolling with a private group

1 health insurance plan offered by a participating in-
2 surer.

3 (6) Each purchasing pool operator shall collect
4 private group health insurance plan premium pay-
5 ments for participating insurers and process such
6 premium payments.

7 (7) Each purchasing pool operator shall rec-
8 oncile from year to year aggregate premium pay-
9 ments and claims costs of private group health in-
10 surance plans consistent with practices under the
11 Federal employees' health benefits program under
12 chapter 89 of title 5, United States Code.

13 (8) Each purchasing pool operator shall offer
14 customer service to eligible individuals enrolled for
15 health benefits coverage under a private group
16 health insurance plan offered by a participating in-
17 surer.

18 (9) Each purchasing pool operator shall ensure
19 that each eligible individual has the option of enroll-
20 ing in either of at least 2 benchmark or benchmark-
21 equivalent plans with—

22 (A) a premium at or below a cap estab-
23 lished by the pool operator for purposes of this
24 title; and

1 (B) coverage of essential services included
2 in the report required under section 501(e)(2),
3 with cost-sharing consistent with such report.

4 (10) Each purchasing pool operator shall estab-
5 lish a premium cap for purposes of determining the
6 credit limitation under section 36(c) of the Internal
7 Revenue Code of 1986, as added by section 311(a).
8 The cap required under this paragraph may not be
9 less than the premium charged to Federal employees
10 by the most highly-enrolled health plan under the
11 Federal employees' health benefits program under
12 chapter 89 of title 5, United States Code. If the
13 most highly-enrolled plan in that program differs for
14 Federal enrollees in the State and all Federal enroll-
15 ees nationally in such plan, the minimum permitted
16 premium cap shall be the lower of such premiums.

17 **SEC. 405. CONTRACTS WITH PARTICIPATING INSURERS.**

18 (a) IN GENERAL.—Each purchasing pool operator
19 shall negotiate and enter into contracts for the provision
20 of health benefits coverage under the program under this
21 title with entities that meet the conditions of participation
22 described in subsection (b) and other applicable require-
23 ments of this Act.

24 (b) CONSUMER INFORMATION.—In carrying out its
25 duty under section 404(c)(4) to inform eligible individuals

1 about private group health plans, the purchasing pool op-
2 erator shall provide information that meets the require-
3 ments of section 412(b)(2).

4 (c) STATE LICENSURE.—

5 (1) IN GENERAL.—Subject to paragraph (2), a
6 health plan shall not be a participating insurer un-
7 less the plan has a State license to provide State
8 residents with the private group coverage health in-
9 surance plans that it offers through the pool.

10 (2) EXCEPTION.—A pool operator may enter
11 into a contract under subsection (a) to cover pool
12 participants through a health plan without a State
13 license described in paragraph (1) if such plan is of-
14 fered to Federal employees nationwide and, with re-
15 spect to such employees, is exempt from State health
16 insurance regulation. Nothing in this paragraph
17 shall be construed to permit coverage of pool partici-
18 pants through such a plan except with groups, con-
19 tracts, and premium rates that are entirely distinct
20 from those used for individuals covered under the
21 Federal employee's health benefits program under
22 chapter 89 of title 5, United States Code.

23 (d) ADDITIONAL STOP-LOSS COVERAGE AND REIN-
24 SURANCE.—Purchasing pool operators are authorized to
25 encourage participation in the program under this title,

1 improve covered benefits, reduce out-of-pocket cost-shar-
2 ing, limit premiums, or achieve other objectives of this Act
3 by—

4 (1) funding stop-loss coverage above levels oth-
5 erwise offered in the purchasing pool; or

6 (2) providing or subsidizing reinsurance in ad-
7 dition to that provided under section 411.

8 (e) PARTICIPATION OF FEHBP PLANS.—

9 (1) IN GENERAL.—Each entity with a contract
10 under section 8902 of title 5, United States Code,
11 shall be a participating insurer unless such entity
12 notifies the Secretary in writing of its intention not
13 to participate in the program under this title prior
14 to such time as is designated by the Secretary so as
15 to allow such decisions to be taken into account with
16 respect to eligible individuals' choice of a private
17 group health insurance plan under such program.
18 Such participation in the program under this title
19 shall include at least the covered benefits and pro-
20 vider networks available through such an entity and
21 shall not involve greater out-of-pocket cost-sharing
22 than the plan offered by such entity pursuant to its
23 contract under section 8902 of title 5, United States
24 Code.

1 (2) NO EFFECT ON FEHBP COVERAGE.—The
 2 Director of Office of Personnel Management shall
 3 take such steps as are necessary to ensure that each
 4 individual enrolled for health benefits coverage under
 5 the program under chapter 89 of title 5, United
 6 States Code, is not adversely affected by eligible in-
 7 dividuals or others enrolled for coverage under the
 8 program under this title. Such steps shall include
 9 (but need not be limited to) the establishment of
 10 separate risk pools, separate contracts with partici-
 11 pating insurers, and separately negotiated pre-
 12 miums.

13 **SEC. 406. OPTIONS FOR HEALTH BENEFITS COVERAGE.**

14 (a) SCOPE OF HEALTH BENEFITS COVERAGE.—The
 15 health benefits coverage provided to an eligible individual
 16 under a private group health insurance plan offered by
 17 a participating insurer shall consist of any of the fol-
 18 lowing:

19 (1) BENCHMARK COVERAGE.—Health benefits
 20 coverage that is equivalent to the benefits coverage
 21 in a benchmark benefit package described in sub-
 22 section (b).

23 (2) BENCHMARK-EQUIVALENT COVERAGE.—
 24 Health benefits coverage that meets the following re-
 25 quirements:

1 (A) INCLUSION OF ESSENTIAL SERV-
 2 ICES.—The coverage includes each of the essen-
 3 tial services identified by the National Advisory
 4 Commission on Expanded Access to Health
 5 Care and adopted by Congress under title III.

6 (B) AGGREGATE ACTUARIAL VALUE EQUIV-
 7 ALENT TO BENCHMARK PACKAGE.—The cov-
 8 erage has an aggregate actuarial value that is
 9 equal to or greater than the actuarial value of
 10 one of the benchmark benefit packages.

11 (3) ALTERNATIVE COVERAGE.—Any other
 12 health benefits coverage that the Secretary deter-
 13 mines, upon application by a State, offers health
 14 benefits coverage equivalent to or greater than a
 15 plan described in and offered under section 8903(1)
 16 of title 5, United States Code.

17 (b) BENCHMARK BENEFIT PACKAGES.—The bench-
 18 mark benefit packages are as follows:

19 (1) FEHBP-EQUIVALENT HEALTH BENEFITS
 20 COVERAGE.—The plan described in and offered
 21 under chapter 89 of title 5, United States Code with
 22 the highest number of enrollees under such section
 23 for the year preceding the year in which the private
 24 group health insurance plan is proposed to be of-
 25 fered.

1 (2) PUBLIC PROGRAM-EQUIVALENT HEALTH
 2 BENEFITS COVERAGE.—Coverage provided under the
 3 State plan approved under the medicaid program
 4 under title XIX of the Social Security Act or the
 5 State children’s health insurance program under
 6 title XXI of such Act (42 U.S.C. 1396 et seq.,
 7 1397aa et seq.) (without regard to coverage provided
 8 under a waiver of the requirements of either such
 9 program).

10 (3) COVERAGE OFFERED THROUGH HMO.—The
 11 health insurance coverage plan that—

12 (A) is offered by a health maintenance or-
 13 ganization (as defined in section 2791(b)(3) of
 14 the Public Health Service Act (42 U.S.C. 33gg–
 15 91(b)(3))); and

16 (B) has the largest insured commercial,
 17 nonmedicaid enrollment of covered lives of such
 18 coverage plans offered by such a health mainte-
 19 nance organization in the State.

20 (4) STATE EMPLOYEE COVERAGE.—The health
 21 insurance plan that is offered to State employees
 22 and has the largest enrollment of covered lives of
 23 any such plan.

24 (5) APPLICATION OF BENCHMARK STAND-
 25 ARDS.—A private group health plan offers bench-

1 mark benefits if, with respect to a benchmark plan
2 described in paragraph (1), (2), (3), or (4), the pri-
3 vate group health plan covers all items and services
4 offered by the benchmark plan, with out-of-pocket
5 cost-sharing for such items and services that is not
6 greater than under the benchmark plan. Nothing in
7 this title shall be construed to forbid a private group
8 health plan from offering additional items and serv-
9 ices not covered by such a benchmark plan or reduc-
10 ing out-of-pocket cost-sharing below levels applicable
11 under such plan.

12 **SEC. 407. ENROLLMENT PROCESS FOR ELIGIBLE INDIVID-**
13 **UALS.**

14 (a) IN GENERAL.—The Secretary shall establish a
15 process through which an eligible individual—

16 (1) may make an annual election to enroll in
17 any private group health insurance plan offered by
18 a participating insurer that has been awarded a con-
19 tract under section 405(a) and serves the geographic
20 area in which the individual resides, provided that
21 such insurer's geographic area of service and guar-
22 anteed issuance under this section is conterminous
23 with, or includes all of, a geographic area served
24 pursuant to an entity's contract under section 8902
25 of title 5, United States Code; and

1 (2) may make an annual election to change the
2 election under this clause.

3 (b) RULES.—In establishing the process under sub-
4 section (a), the Secretary shall use rules similar to the
5 rules for enrollment, disenrollment, and termination of en-
6 rollment under the Federal employees health benefits pro-
7 gram under chapter 89 of title 5, United States Code, in-
8 cluding the application of the guaranteed issuance provi-
9 sion described in subsection (c).

10 (c) GUARANTEED ISSUANCE.—An eligible individual
11 who is eligible to enroll for health benefits coverage under
12 a private group health insurance plan that has been
13 awarded a contract under section 405(a) at a time during
14 which elections are accepted under this title with respect
15 to the plan shall not be denied enrollment based on any
16 health status-related factor (described in section
17 2702(a)(1) of the Public Health Service Act (42 U.S.C.
18 300gg–1(a)(1))) or any other factor.

19 **SEC. 408. PLAN PREMIUMS.**

20 (a) IN GENERAL.—Each purchasing pool operator
21 shall negotiate (or, in the case of a purchasing pool oper-
22 ated pursuant to section 403(b)(1)(B), shall otherwise de-
23 termine) a premium for each private group health insur-
24 ance plan offered by a participating insurer.

25 (b) PERMITTED PROFIT MARGINS.—

1 (1) IN GENERAL.—Each premium negotiated
 2 under subsection (a) may not permit a profit margin
 3 that exceeds the applicable percentage (as defined in
 4 paragraph (2)).

5 (2) APPLICABLE PERCENTAGE DEFINED.—In
 6 this subsection, the term “applicable percentage”
 7 means—

8 (A) for the first 3 years that a purchasing
 9 pool is operated, 2 percent;

10 (B) for any subsequent year, the percent-
 11 age determined by the purchasing pool oper-
 12 ator, which may not be—

13 (i) less than the profit margin per-
 14 mitted under the Federal employees health
 15 benefits program under chapter 89 of title
 16 5, United States Code; or

17 (ii) more than a multiple, established
 18 by the Secretary for purposes of this sub-
 19 section, of profit margins permitted under
 20 such program.

21 **SEC. 409. ENROLLEE PREMIUM SHARE.**

22 (a) IN GENERAL.—A participating insurer offering a
 23 private group health insurance plan that has been awarded
 24 a contract under section 405(a) in which the eligible indi-
 25 vidual is enrolled may not deny, limit, or condition the

1 coverage (including out-of-pocket cost-sharing) or provi-
 2 sion of health benefits coverage or vary or increase the
 3 enrollee premium share under the plan based on any
 4 health status-related factor described in section
 5 2702(a)(1) of the Public Health Service Act (42 U.S.C.
 6 300gg-1(a)(1)) or any other factor.

7 (b) RISK-ADJUSTED PLAN PAYMENTS AND PRE-
 8 MIUMS CHARGED TO ENROLLEES.—

9 (1) IN GENERAL.—For each private group
 10 health insurance plan operated by a participating in-
 11 surer, the pool operator shall adjust premium pay-
 12 ments to compensate for the difference in health risk
 13 factors between plan enrollees and State residents as
 14 a whole (including residents who are not eligible in-
 15 dividuals). Such adjustments shall employ risk-ad-
 16 justment mechanisms promulgated by the Secretary.

17 (2) ADDITIONAL ADJUSTMENTS.—The pool op-
 18 erator shall also provide additional adjustments to
 19 premium payments that compensate participating in-
 20 surers for the cost of keeping out-of-pocket cost-
 21 sharing amounts consistent with section
 22 404(c)(9)(B).

23 (3) ENROLLEE PREMIUM COSTS.—The adjust-
 24 ments described in this subsection shall not affect
 25 enrollee premium shares, which shall be based on the

1 premium that would be charged for enrollees with
 2 health risk factors for State residents as a whole (as
 3 described in paragraph (1)), without taking into ac-
 4 count cost-sharing adjustments under section
 5 404(c)(9)(B).

6 (c) AMOUNT OF PREMIUM.—The amount of the en-
 7 rollee premium share shall be equal to premium amounts
 8 (if any) above the applicable cap set pursuant to section
 9 404(c)(10), plus 100 percent of the remainder minus the
 10 applicable percentage (as defined in section 36(b) of the
 11 Internal Revenue Code of 1986, as added by section 311).

12 **SEC. 410. PAYMENTS TO PURCHASING POOL OPERATORS**
 13 **AND PAYMENTS TO PARTICIPATING INSUR-**
 14 **ERS.**

15 The Secretary shall establish procedures for making
 16 payments to each purchasing pool operator as follows:

17 (1) RISK-ADJUSTMENT PAYMENT.—The Sec-
 18 retary shall pay each purchasing pool operator for
 19 the net costs of risk-adjusted payments to plans
 20 under section 409(b), to the extent the sum of up-
 21 ward adjustments exceeds the sum of downward ad-
 22 justments for the pool operator.

23 (2) STOP-LOSS AND REINSURANCE PAY-
 24 MENTS.—

1 (A) IN GENERAL.—The Secretary shall pay
2 each purchasing pool operator for the applicable
3 percentage (as defined in subparagraph (B))
4 of—

5 (i) the costs of any stop-loss coverage
6 funded by the purchasing pool operator
7 under section 405(d)(1); and

8 (ii) any reinsurance provided in ac-
9 cordance with section 405(d)(2).

10 (B) APPLICABLE PERCENTAGE DE-
11 FINED.—In this paragraph, the term “applica-
12 ble percentage” means—

13 (i) for the first 3 years that a pur-
14 chasing pool is operated, 100 percent;

15 (ii) for the next 2 years that such
16 purchasing pool is operated, 50 percent;
17 and

18 (iii) for any subsequent year, 0 per-
19 cent.

20 (3) PAYMENTS NECESSARY TO KEEP COST-
21 SHARING WITHIN APPLICABLE LIMITS.—The Sec-
22 retary shall make payments to purchasing pool oper-
23 ators to reimburse purchasing pool operators for the
24 amount paid by such operators to participating in-
25 surers necessary to keep out-of-pocket cost-sharing

1 for individuals with limited ability to pay within ap-
2 plicable limits.

3 (4) PAYMENT FOR ADMINISTRATIVE COSTS.—

4 The Secretary shall make payments to each pur-
5 chasing pool operator for necessary pool administra-
6 tive expenses.

7 (5) PAYMENTS TO OPM.—In the case of a pur-
8 chasing pool described in section 403(b)(1)(B), pay-
9 ments under this section shall be made to the Direc-
10 tor of the Office of Personnel Management.

11 **SEC. 411. STATE-BASED REINSURANCE PROGRAMS.**

12 (a) ESTABLISHMENT.—The Secretary shall establish
13 standards for State-based reinsurance programs for eligi-
14 ble individuals to guard against adverse selection and to
15 improve the functioning of the individual health insurance
16 market.

17 (b) GRANTS FOR STATEWIDE REINSURANCE PRO-
18 GRAMS.—

19 (1) IN GENERAL.—The Secretary may award
20 grants to States for the reasonable costs incurred in
21 providing reinsurance under this section, consistent
22 with standards developed by the Secretary, for cov-
23 erage offered in the individual health insurance mar-
24 ket and through State-based purchasing pools de-
25 scribed in section 403.

1 (2) LIMITATION.—Such grants may not pay for
2 reinsurance extending beyond individuals in the top
3 3 percent of the national health care spending dis-
4 tribution, as determined by the Secretary.

5 (3) APPLICATION.—A State desiring a grant
6 under this section shall submit an application to the
7 Secretary in such manner, at such time, and con-
8 taining such information as the Secretary may re-
9 quire.

10 (4) AUTHORIZATION OF APPROPRIATIONS.—
11 There are authorized to be appropriated to the Sec-
12 retary such sums as may be necessary for making
13 grants under this section.

14 **SEC. 412. COVERAGE UNDER INDIVIDUAL HEALTH INSUR-**
15 **ANCE.**

16 (a) IN GENERAL.—Eligible individuals may use cred-
17 its allowed under the Internal Revenue Code of 1986 (in-
18 cluding supplemental assistance provided under such
19 Code) for the purchase of health insurance coverage to en-
20 roll in State-licensed individual health insurance meeting
21 the conditions of participation described in subsection (b).

22 (b) CONDITIONS OF PARTICIPATION.—The Secretary
23 shall promulgate regulations that establish the terms and
24 conditions under which an entity may participate in the
25 program under this section and that include the following:

1 (1) PLAN MARKETING.—Conditions of partici-
2 pation for plans in the individual market (as devel-
3 oped by the Secretary) that—

4 (A) ensure that consumers receive the con-
5 sumer information described in paragraph (2)
6 before selecting a plan; and

7 (B) detect, deter, and penalize marketing
8 fraud by entities offering or purporting to offer
9 individual insurance.

10 (2) CONSUMER INFORMATION.—Requirements
11 for each entity offering individual insurance to pro-
12 vide eligible individuals with information in a uni-
13 form and easily comprehensible manner that allows
14 for informed comparisons by eligible individuals and
15 that includes information regarding the health bene-
16 fits coverage, costs, provider networks, quality, the
17 amount and proportion of health insurance premium
18 payments that go directly to patient care, and the
19 plan’s coverage rules (including amount, duration,
20 and scope limits) and out-of-pocket cost-sharing
21 (both inside and outside plan networks) for each es-
22 sential service recommended by the National Advi-
23 sory Commission on Expanded Access to Health
24 Care and adopted by Congress under title III (which
25 shall be prominently identified as an essential serv-

1 ice, including by reference to the Commission rec-
2 ommendation denoting the service as essential). To
3 the maximum extent feasible, such requirements
4 shall specify that the content and presentation of the
5 information shall be provided in the same manner as
6 similar information is presented to enrollees in the
7 Federal employees health benefits program under
8 chapter 89 of title 5, United States Code.

9 (3) OTHER CONDITIONS, INCLUDING THE
10 ELIMINATION OF BARRIERS TO AFFORDABLE COV-
11 ERAGE.—

12 (A) IN GENERAL.—Requirements for each
13 entity offering individual insurance to abide by
14 conditions of participation that the Secretary
15 believes are reasonable and appropriate meas-
16 ures to address barriers to affordable health in-
17 surance coverage.

18 (B) SPECIFIC CONDITIONS.—The require-
19 ments developed by the Secretary under sub-
20 paragraph (A) shall include (but need not be
21 limited to)—

22 (i) guaranteed renewability, without
23 premium increases based on changed indi-
24 vidual risk; and

25 (ii) limits on risk rating.

1 (4) RULE OF CONSTRUCTION.—Nothing in this
2 section shall be construed to authorize the Secretary
3 to impose any requirements on individual insurance,
4 except with respect to eligible individuals purchasing
5 individual insurance using advance payment of a tax
6 credit provided under section 36 of the Internal Rev-
7 enue Code of 1986.

8 **SEC. 413. USE OF PREMIUM SUBSIDIES TO UNIFY FAMILY**
9 **COVERAGE WITH MEMBERS ENROLLED IN**
10 **MEDICAID AND SCHIP.**

11 Notwithstanding any other provision of law, the Sec-
12 retary shall establish procedures under which, in the case
13 of a family with 1 or more members enrolled in with a
14 managed care entity under the State medicaid program
15 under title XIX of the Social Security Act or the State
16 children's health insurance program under title XXI of
17 such Act (42 U.S.C. 1396 et seq., 1397aa et seq.) and
18 1 or more members who are an eligible individual under
19 this title, the family shall have the option to enroll all fam-
20 ily members with the managed care entity under either
21 or both such State programs. The procedures established
22 by the Secretary shall provide that premiums charged to
23 eligible individuals for enrollment with such an entity shall
24 be based on the capitated payments established for adults
25 or children, excluding adults and children who are known

1 to be pregnant, blind, disabled, or (in the case of adults)
 2 elderly, under the applicable State program (except that,
 3 in the case of an eligible individual known to be pregnant,
 4 premiums shall reflect capitated payments established
 5 under such State program for individuals known to be
 6 pregnant) plus reasonable administrative costs.

7 **SEC. 414. COVERAGE THROUGH EMPLOYER-SPONSORED**
 8 **HEALTH INSURANCE.**

9 (a) IN GENERAL.—Eligible individuals may use cred-
 10 its allowed under the Internal Revenue Code of 1986 and
 11 supplemental assistance to enroll in coverage offered by
 12 eligible employers.

13 (b) ELIGIBLE EMPLOYERS.—For purposes of this
 14 section, the term “eligible employers” includes the fol-
 15 lowing:

16 (1) The current employer of the eligible indi-
 17 vidual or a member of such individual’s family.

18 (2) A former employer required to offer cov-
 19 erage of the eligible individual under a COBRA con-
 20 tinuation provision (as defined in section 9832(d)(1)
 21 of the Internal Revenue Code) or a State law requir-
 22 ing continuation coverage; and

23 (3) A former employer voluntarily offering cov-
 24 erage of the eligible individual.

1 (c) APPLICATION OF DISREGARD OF PREEXISTING
2 CONDITIONS EXCLUSIONS.—Notwithstanding any other
3 provision of law, in the case of an individual who experi-
4 ences a qualifying event (as defined in section 603 of the
5 Employee Retirement Income Security Act of 1974 (29
6 U.S.C. 1163) and who, not later than 6 months after such
7 event, is determined to be an eligible individual under this
8 title, the same rules with respect to preexisting conditions
9 as apply to a nonelecting TAA-eligible individual under
10 section 605(b) of the Employee Retirement Income Secu-
11 rity Act of 1974 (29 U.S.C. 1165(b)) shall apply with re-
12 spect to such individual, regardless of which type of quali-
13 fied coverage the individual purchases.

14 (d) EXTENSION OF COBRA ELECTION PERIOD.—
15 Notwithstanding any other provision of law, in the case
16 of an individual who experiences a qualifying event (as de-
17 fined in section 603 of the Employee Retirement Income
18 Security Act of 1974 (29 U.S.C. 1163) and who, not later
19 than 6 months after such event, is determined to be an
20 eligible individual under this title, the same rules with re-
21 spect to the temporary extension of a COBRA election pe-
22 riod as apply to a nonelecting TAA-eligible individual
23 under section 605(b) of the Employee Retirement Income
24 Security Act of 1974 (29 U.S.C. 1165(b)) shall apply with
25 respect to such individual.

1 (e) CURRENT EMPLOYER COVERAGE.—If an eligible
2 individual uses the credits allowed under the Internal Rev-
3 enue Code of 1986 and supplemental assistance to pur-
4 chase coverage from an employer described in subsection
5 (b), such credits and assistance shall apply as a percent-
6 age, not of the total premium amount for the eligible indi-
7 vidual, but of the employee’s or former employee’s share
8 of premium payments.

9 **SEC. 415. PARTICIPATION BY SMALL EMPLOYERS.**

10 (a) IN GENERAL.—Notwithstanding any other provi-
11 sion of this title, the Secretary shall establish procedures
12 under which, during annual open enrollment periods, a
13 small employer shall have the option of purchasing group
14 coverage for employees and dependents of employees, in-
15 cluding individuals who are not otherwise eligible individ-
16 uals under this title, through a purchasing pool established
17 under section 403(a).

18 (b) CONDITIONS OF PARTICIPATION.—

19 (1) IN GENERAL.—Except as otherwise pro-
20 vided in this subsection, the same requirements that
21 apply with respect to participating insurers covering
22 eligible low-income individuals under section 403
23 shall apply with respect to coverage offered by such
24 insurers through a small employer.

25 (2) RISK ADJUSTMENT.—

1 (A) INCREASED PAYMENTS.—If employees
2 of a small employer who are not otherwise eligi-
3 ble individuals under this title enroll in a pri-
4 vate group health insurance plan under this
5 title and have a collective risk level that exceeds
6 the statewide average (as determined pursuant
7 to risk adjustment mechanisms developed by
8 the Secretary consistent with section
9 409(b)(1)), the Secretary (through a pool oper-
10 ator) shall provide participating insurers with
11 such small employer enrollment bonus payments
12 as are necessary to compensate the insurers for
13 such increased risk. The premium charged to
14 enrollees under this section shall be the same
15 premium that is the basis of premium charges
16 to enrollees who are eligible low-income individ-
17 uals.

18 (B) REDUCED PAYMENTS.—A pool oper-
19 ator shall reduce payments to any plan with a
20 risk level that falls below the statewide average
21 (as so determined).

22 (3) ADMINISTRATIVE GUIDELINES.—The Sec-
23 retary shall develop guidelines for pool operators to
24 use in serving small employers, which shall be mod-
25 eled after existing, successful, longstanding small

1 business purchasing cooperatives, and shall include
2 administratively simple methods for small employers
3 and licensed insurance brokers to participate in the
4 program established under this title.

5 (c) INFORMATION CAMPAIGN.—

6 (1) IN GENERAL.—The pool operator for a
7 State shall establish and conduct, directly or
8 through 1 or more public or private entities (which
9 may include licensed insurance brokers), a health in-
10 surance information program to inform small em-
11 ployers about health coverage for employees.

12 (2) REQUIREMENTS.—The program established
13 under paragraph (1) shall educate small employers
14 with respect to matters that include (but are not
15 limited to) the following:

16 (A) The benefits of providing health insur-
17 ance to employees, including tax benefits to
18 both the employer and employees, increased
19 productivity, and decreased employee turnover.

20 (B) The rights of small employers under
21 Federal and State health insurance reform
22 laws.

23 (C) Options for purchasing coverage, in-
24 cluding (but not limited to) through the State's

1 purchasing pool operated pursuant to section
2 403.

3 (d) GRANTS TO HELP STATE-BASED POOLS PRO-
4 MOTE SMALL BUSINESS COVERAGE.—

5 (1) IN GENERAL.—The Secretary may award
6 grants to a pool operator for the following:

7 (A) The net costs of risk-adjusted pay-
8 ments under paragraph (b)(2), to the extent the
9 sum of upward adjustments exceeds the sum of
10 downward adjustments for the pool operator.

11 (B) The reasonable cost of the information
12 campaign under subsection (c).

13 (C) The pool operator's reasonable admin-
14 istrative costs to implement this section.

15 (2) LIMITATION.—This section shall not apply
16 to a State's pool unless sufficient grant funds have
17 been received under this subsection to implement
18 this section on a fiscally sound basis and such re-
19 ceipt is certified by the pool operator.

20 (3) APPLICATION.—A pool operator desiring a
21 grant under this section shall submit an application
22 to the Secretary in such manner, at such time, and
23 containing such information as the Secretary may
24 require.

1 (4) AUTHORIZATION OF APPROPRIATIONS.—

2 There are authorized to be appropriated to the Sec-
3 retary such sums as may be necessary for making
4 grants under this subsection.

5 **SEC. 416. REPORT.**

6 Not later than 1 year after the date of enactment
7 of this Act, the Secretary shall submit to Congress a re-
8 port containing recommendations for such legislative and
9 administrative changes as the Secretary determines are
10 appropriate to permit affinity groups related for reasons
11 other than a common employer to participate in pur-
12 chasing pools established under section 403.

13 **SEC. 417. AUTHORIZATION OF APPROPRIATIONS.**

14 (a) IN GENERAL.—There are authorized to be appro-
15 priated, such sums as may be necessary to carry out this
16 title for fiscal year 2010 and each fiscal year thereafter.

17 (b) RULE OF CONSTRUCTION.—Amounts appro-
18 priated in accordance with subsection (a) shall be in addi-
19 tion to other amounts appropriated directly under this
20 title and nothing in subsection (a) shall be construed to
21 relieve the Secretary of mandatory payment obligations re-
22 quired under this title.

1 **TITLE V—NATIONAL ADVISORY**
2 **COMMISSION ON EXPANDED**
3 **ACCESS TO HEALTH CARE**

4 **SEC. 501. NATIONAL ADVISORY COMMISSION ON EXPANDED**
5 **ACCESS TO HEALTH CARE.**

6 (a) ESTABLISHMENT.—Not later than October 1,
7 2007, the Secretary of Health and Human Services (re-
8 ferred to in this section as the “Secretary”), shall estab-
9 lish an entity to be known as the National Advisory Com-
10 mission on Expanded Access to Health Care (referred to
11 in this section as the “Commission”).

12 (b) APPOINTMENT OF MEMBERS.—

13 (1) IN GENERAL.—Not later than 45 days after
14 the date of enactment of this Act, the House and
15 Senate majority and minority leaders shall each ap-
16 point 4 members of the Commission and the Sec-
17 retary shall appoint 1 member.

18 (2) CRITERIA.—Members of the Commission
19 shall include representatives of the following:

- 20 (A) Consumers of health insurance.
21 (B) Health care professionals.
22 (C) State officials.
23 (D) Economists.
24 (E) Health care providers.
25 (F) Experts on health insurance.

1 (G) Experts on expanding health care to
2 individuals who are uninsured.

3 (3) CHAIRPERSON.—At the first meeting of the
4 Commission, the Commission shall select a Chair-
5 person from among its members.

6 (c) MEETINGS.—

7 (1) IN GENERAL.—After the initial meeting of
8 the Commission which shall be called by the Sec-
9 retary, the Commission shall meet at the call of the
10 Chairperson.

11 (2) QUORUM.—A majority of the members of
12 the Commission shall constitute a quorum, but a
13 lesser number of members may hold hearings.

14 (3) SUPERMAJORITY VOTING REQUIREMENT.—
15 To approve a report required under paragraph (2)
16 or (3) of subsection (e), at least 60 percent of the
17 membership of the Commission must vote in favor of
18 such a report.

19 (d) DUTIES.—The Commission shall—

20 (1) assess the effectiveness of programs de-
21 signed to expand health care coverage or make
22 health care coverage affordable to the otherwise un-
23 insured individuals through identifying the accom-
24 plishments and needed improvements of each pro-
25 gram;

1 (2) make recommendations about benefits and
2 cost-sharing to be included in health care coverage
3 for various groups, taking into account—

4 (A) the special health care needs of chil-
5 dren and individuals with disabilities;

6 (B) the different ability of various popu-
7 lations to pay out-of-pocket costs for services;

8 (C) incentives for efficiency and cost-con-
9 trol; and

10 (D) preventative care, disease management
11 services, and other factors;

12 (3) recommend mechanisms to discourage indi-
13 viduals and employers from voluntarily opting out of
14 health insurance coverage;

15 (4) recommend mechanisms to expand health
16 care coverage to uninsured individuals with incomes
17 above 200 percent of the official income poverty line
18 (as defined by the Office of Management and Budg-
19 et, and revised annually in accordance with section
20 673(2) of the Omnibus Budget Reconciliation Act of
21 1981) applicable to a family of the size involved;

22 (5) recommend automatic enrollment and reten-
23 tion procedures and other measures to increase
24 health care coverage among those eligible for assist-
25 ance;

1 (6) review the roles, responsibilities, and rela-
2 tionship between Federal and State agencies with re-
3 spect to health care coverage and recommend im-
4 provements; and

5 (7) analyze the size, effectiveness, and efficiency
6 of current tax and other subsidies for health care
7 coverage and recommend improvements.

8 (e) REPORTS.—

9 (1) ANNUAL REPORT.—The Commission shall
10 submit annual reports to the President and Con-
11 gress addressing the matters identified in subsection
12 (d).

13 (2) BIENNIAL REPORT.—

14 (A) IN GENERAL.—The Commission shall
15 submit biennial reports to the President and
16 Congress, which shall contain—

17 (i) recommendations concerning essen-
18 tial benefits and maximum out-of-pocket
19 cost-sharing (for the general population
20 and for individuals with limited ability to
21 pay, which shall not exceed the out-of-
22 pocket cost-sharing permitted under sec-
23 tion 2103(e) of the Social Security Act (42
24 U.S.C. 1397cc(e))) for the coverage op-
25 tions described in title IV; and

1 (ii) proposed legislative language to
2 implement such recommendations.

3 (B) CONGRESSIONAL ACTION.—The legis-
4 lative language proposed under subparagraph
5 (A)(ii) shall proceed to immediate consideration
6 on the floor of the House of Representatives
7 and the Senate and shall be approved or re-
8 jected, without amendment, using procedures
9 employed for recommendations of military base
10 closing commissions.

11 (3) COMMISSION REPORT.—No later than Janu-
12 ary 15, 2011, the Commission shall submit a report
13 to the President and Congress, which shall include—

14 (A) recommendations on policies to provide
15 health care coverage to uninsured individuals
16 with incomes above 200 percent of the official
17 income poverty line (as defined by the Office of
18 Management and Budget, and revised annually
19 in accordance with section 673(2) of the Omni-
20 bus Budget Reconciliation Act of 1981) applica-
21 ble to a family of the size involved;

22 (B) recommendations on changes to poli-
23 cies enacted under this Act; and

24 (C) proposed legislative language to imple-
25 ment such recommendations.

1 (f) ADMINISTRATION.—

2 (1) POWERS.—

3 (A) HEARINGS.—The Commission may
4 hold such hearings, sit and act at such times
5 and places, take such testimony, and receive
6 such evidence as the Commission considers ad-
7 visable to carry out this section.

8 (B) INFORMATION FROM FEDERAL AGEN-
9 CIES.—The Commission may secure directly
10 from any Federal department or agency such
11 information as the Commission considers nec-
12 essary to carry out this section. Upon request
13 of the Chairperson of the Commission, the head
14 of such department or agency shall furnish such
15 information to the Commission.

16 (C) POSTAL SERVICES.—The Commission
17 may use the United States mails in the same
18 manner and under the same conditions as other
19 departments and agencies of the Federal Gov-
20 ernment.

21 (D) GIFTS.—The Commission may accept,
22 use, and dispose of gifts or donations of serv-
23 ices or property.

24 (2) COMPENSATION.—While serving on the
25 business of the Commission (including travel time),

1 a member of the Commission shall be entitled to
2 compensation at the per diem equivalent of the rate
3 provided for level IV of the Executive Schedule
4 under section 5315 of title 5, United States Code,
5 and while so serving away from home and the mem-
6 ber's regular place of business, a member may be al-
7 lowed travel expenses, as authorized by the chair-
8 person of the Commission. All members of the Com-
9 mission who are officers or employees of the United
10 States shall serve without compensation in addition
11 to that received for their services as officers or em-
12 ployees of the United States.

13 (3) STAFF.—

14 (A) IN GENERAL.—The Chairperson of the
15 Commission may, without regard to the civil
16 service laws and regulations, appoint and termi-
17 nate an executive director and such other addi-
18 tional personnel as may be necessary to enable
19 the Commission to perform its duties. The em-
20 ployment of an executive director shall be sub-
21 ject to confirmation by the Commission.

22 (B) STAFF COMPENSATION.—The Chair-
23 person of the Commission may fix the com-
24 pensation of the executive director and other
25 personnel without regard to chapter 51 and

1 subchapter III of chapter 53 of title 5, United
2 States Code, relating to classification of posi-
3 tions and General Schedule pay rates, except
4 that the rate of pay for the executive director
5 and other personnel may not exceed the rate
6 payable for level V of the Executive Schedule
7 under section 5316 of such title.

8 (C) DETAIL OF GOVERNMENT EMPLOY-
9 EES.—Any Federal Government employee may
10 be detailed to the Commission without reim-
11 bursement, and such detail shall be without
12 interruption or loss of civil service status or
13 privilege.

14 (D) PROCUREMENT OF TEMPORARY AND
15 INTERMITTENT SERVICES.—The Chairperson of
16 the Commission may procure temporary and
17 intermittent services under section 3109(b) of
18 title 5, United States Code, at rates for individ-
19 uals which do not exceed the daily equivalent of
20 the annual rate of basic pay prescribed for level
21 V of the Executive Schedule under section 5316
22 of such title.

23 (g) TERMINATION.—Except with respect to activities
24 in connection with the ongoing biennial report required
25 under subsection (e)(2), the Commission shall terminate

1 90 days after the date on which the Commission submits
2 the report required under subsection (e)(3).

3 (h) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated, such sums as may be
5 necessary to carry out this section for fiscal year 2008
6 and each fiscal year thereafter.

7 **SEC. 502. CONGRESSIONAL ACTION.**

8 (a) BILL INTRODUCTION.—

9 (1) IN GENERAL.—Any legislative language in-
10 cluded in the report required under section
11 501(e)(3) may be introduced as a bill by request in
12 the following manner:

13 (A) HOUSE OF REPRESENTATIVES.—In the
14 House of Representatives, by the majority lead-
15 er and the minority leader not later than 10
16 days after receipt of the legislative language.

17 (B) SENATE.—In the Senate, by the ma-
18 jority leader and the minority leader not later
19 than 10 days after receipt of the legislative lan-
20 guage.

21 (2) ALTERNATIVE BY ADMINISTRATION.—The
22 President may submit legislative language based on
23 the recommendations of the Commission and such
24 legislative language may be introduced in the man-
25 ner described in paragraph (1).

1 (b) COMMITTEE CONSIDERATION.—

2 (1) IN GENERAL.—Any legislative language
3 submitted pursuant to paragraph (1) or (2) of sub-
4 section (a) (in this section referred to as “imple-
5 menting legislation”) shall be referred to the appro-
6 priate committees of the House of Representatives
7 and the Senate.

8 (2) REPORTING.—

9 (A) COMMITTEE ACTION.—If, not later
10 than 150 days after the date on which the im-
11 plementing legislation is referred to a com-
12 mittee under paragraph (1), the committee has
13 reported the implementing legislation or has re-
14 ported an original bill whose subject is related
15 to reforming the health care system, or to pro-
16 viding access to affordable health care coverage
17 for Americans, the regular rules of the applica-
18 ble House of Congress shall apply to such legis-
19 lation.

20 (B) DISCHARGE FROM COMMITTEES.—

21 (i) SENATE.—

22 (I) IN GENERAL.—If the imple-
23 menting legislation or an original bill
24 described in subparagraph (A) has not
25 been reported by a committee of the

1 Senate within 180 days after the date
2 on which such legislation was referred
3 to committee under paragraph (1), it
4 shall be in order for any Senator to
5 move to discharge the committee from
6 further consideration of such imple-
7 menting legislation.

8 (II) SEQUENTIAL REFERRALS.—

9 Should a sequential referral of the im-
10 plementing legislation be made, the
11 additional committee has 30 days for
12 consideration of implementing legisla-
13 tion before the discharge motion de-
14 scribed in subclause (I) would be in
15 order.

16 (III) PROCEDURE.—The motion

17 described in subclause (I) shall not be
18 in order after the implementing legis-
19 lation has been placed on the cal-
20 endar. While the motion described in
21 subclause (I) is pending, no other mo-
22 tions related to the motion described
23 in subclause (I) shall be in order. De-
24 bate on a motion to discharge shall be
25 limited to not more than 10 hours,

1 equally divided and controlled by the
2 majority leader and the minority lead-
3 er, or their designees. An amendment
4 to the motion shall not be in order,
5 nor shall it be in order to move to re-
6 consider the vote by which the motion
7 is agreed or disagreed to.

8 (IV) EXCEPTION.—If imple-
9 menting language is submitted on a
10 date later than May 1 of the second
11 session of a Congress, the committee
12 shall have 90 days to consider the im-
13 plementing legislation before a motion
14 to discharge under this clause would
15 be in order.

16 (ii) HOUSE OF REPRESENTATIVES.—
17 If the implementing legislation or an origi-
18 nal bill described in subparagraph (A) has
19 not been reported out of a committee of
20 the House of Representatives within 180
21 days after the date on which such legisla-
22 tion was referred to committee under para-
23 graph (1), then on any day on which the
24 call of the calendar for motions to dis-
25 charge committees is in order, any member

1 of the House of Representatives may move
2 that the committee be discharged from
3 consideration of the implementing legisla-
4 tion, and this motion shall be considered
5 under the same terms and conditions, and
6 if adopted the House of Representatives
7 shall follow the procedure described in sub-
8 section (c)(1).

9 (c) FLOOR CONSIDERATION.—

10 (1) MOTION TO PROCEED.—If a motion to dis-
11 charge made pursuant to subsection (b)(2)(B)(i) or
12 (b)(2)(B)(ii) is adopted, then, not earlier than 5 leg-
13 islative days after the date on which the motion to
14 discharge is adopted, a motion may be made to pro-
15 ceed to the bill.

16 (2) FAILURE OF MOTION.—If the motion to dis-
17 charge made pursuant to subsection (b)(2)(B)(i) or
18 (b)(2)(B)(ii) fails, such motion may be made not
19 more than 2 additional times, but in no case more
20 frequently than within 30 days of the previous mo-
21 tion. Debate on each of such motions shall be limited
22 to 5 hours, equally divided.

1 (3) APPLICABLE RULES.—Once the Senate is
2 debating the implementing legislation the regular
3 rules of the Senate shall apply.

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